

0525: AUGIS TRAINEE PRIZE WINNER: ANTIMICROBIAL PROPHYLAXIS PRIOR TO PANCREATICO-DUODENECTOMY

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Aim: At our unit, antimicrobial prophylaxis prior to pancreatoco-duodenectomy (PD) consists of tazocin/fluconazole in patients who had preoperative biliary drainage (PBD), or co-amoxiclav in patients without PBD. The objective of this study was to determine the appropriateness of these regimens by analysis of intraoperative bile samples.

Methods: Retrospective analysis of 60 consecutive patients who underwent PD (May 2011 – April 2012). Data regarding intraoperative bile cultures/sensitivities were recorded.

Results: Intraoperative bile samples were available in 33/36 patients who underwent PBD, and were positive in 30 (91%): bacteria in 26 (single 13, multiple 13) and fungi in 18. Bile samples were available in 16/24 patients in the non-PBD group, of which 5 were positive (31%) for bacterial infection (single in all cases). In the PBD group, bacterial sensitivities were co-amoxiclav 12/26, tazocin 20/26, meropenem+vancomycin 25/26 and ciprofloxacin/gentamicin+metronidazole 16/26. In the non-PBD group, sensitivities were co-amoxiclav 3/5, tazocin 5/5, meropenem+vancomycin 5/5 and ciprofloxacin/gentamicin+metronidazole 4/5. Surgical site infections occurred in 8% of the PBD group and 29% of the non-PBD group.

Conclusions: Anti-fungal prophylaxis is essential prior to pancreatoco-duodenectomy in patients who have undergone preoperative biliary drainage. Regular review of intraoperative bile cultures and tailoring of prophylactic antibiotic regimens is recommended.

0531: ROLE OF ENDOSCOPIC ULTRASOUND AND MULTIDIMENSIONAL COMPUTED TOMOGRAPHY IN PREDICTING NEED FOR MESENTERIC VEIN RESECTION IN PANCREATICO-DUODENECTOMY SPECIMENS – A HISTOPATHOLOGICAL CORRELATION

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In locally advanced pancreatic cancer, portal vein resection has been shown to be a safe and feasible procedure that increases the number of patients who undergo curative resection with a survival benefit.

A retrospective review of a prospectively maintained database of pancreatocoduodenectomy operations performed at National Surgical Centre for Pancreatic Cancer over 36 months (2010–2012) was performed. We looked at the pre-operative prediction of the need for venous resection made at the time of multidisciplinary team evaluation of CT and EUS findings based on current NCCN 'borderline resectable' criteria for venous involvement.

Portal vein resection, with primary repair or reconstruction, was performed in 20 of 218(9%) consecutive procedures. Diagnostic pre-operative 4-Phase CT-Pancreas had been performed in all cases where vein resection was performed while additional EUS was performed in 15/20(75%). Combined preoperative imaging predicted the need for resection in 10 of 20(50%) cases while CT alone predicted only 6/20(30%). The R0 resection rate was 12/20(60%) with 17(85%) patients alive at follow-up.

Despite advances in multi-planar imaging, preoperative radiological evaluation often underestimates the need for mesenteric vein resection. All patients undergoing surgical resection for pancreatic cancer should be consented and assessed for suitability to undergo major venous resection and reconstruction.

0598: BASO ~ THE ASSOCIATION OF CANCER SURGERY PRIZE WINNER: DETERMINING COMPLETE CLINICAL RESPONSE OF RADIOLOGICALLY DISAPPEARING COLORECTAL LIVER METASTASES AFTER CHEMOTHERAPY AND HOW THEY SHOULD BE MANAGED

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Aim: To determine if radiologically disappearing liver metastases (DLMs) after chemotherapy correspond to a complete clinical response. The treatment of DLMs was also assessed to determine whether they should be resected or left in situ.

Methods: A retrospective review was carried out on 342 patients referred for surgical opinion between January 2001 and January 2012. Twenty-

eight patients showed evidence of at least one metastasis disappearing radiologically after chemotherapy. 16 patients were subsequently eligible for review, median follow up of 27.6 months (range 5.2 – 113.9 months).

Results: 35 metastases were identified in 16 patients. Twenty-eight metastases disappeared on imaging. 10 patients had 15 DLMs left in situ and 6 patients had 13 DLMs resected. Complete clinical response was observed in 15 DLMs (53.6%) on follow up. Five showed no recurrence within one year in those left in situ (33.3%) and 10 showed complete pathological response after resection (76.9%). A significantly reduced recurrence free survival was observed in the in situ group, [6.3 vs 19.4 months ($p < 0.001$)], but overall survival was not significantly different between the two groups ($p = 0.12$).

Conclusion: DLMs radiologically do not necessarily confer a complete clinical response. They should be resected when possible but leaving them in situ can be warranted.

0826: IS NORMAL MACROSCOPIC APPEARANCE OF THE GALLBLADDER FOLLOWING CHOLECYSTECTOMY SUFFICIENT TO EXCLUDE MALIGNANCY?

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Aims: Occasionally, histological examination of the gallbladder following routine cholecystectomy reveals an incidental cancer. We aim to assess whether inspection of the gallbladder postoperatively, followed by histological examination of macroscopically abnormal specimens only, could be a safe and cost-effective alternative to routine histological examination in every case.

Methods: Patients undergoing emergency or elective cholecystectomy between 1 May 2003 and 1 September 2010 were included. Pathology records were used to identify all gallbladder malignancies. Only gallbladder cancers picked up incidentally following cholecystectomy were included. Pathology reports were reviewed to establish whether there was a macroscopic abnormality.

Results: 4776 patients were identified, including 532 emergencies. Overall median age was 54 years (range 14 – 95), Male:Female = 1:3. Of these, 13(0.27%) were found to have cancer; these patients had a median age of 68 years (range 48–84). 42% of cancer cases were emergency admissions (5 patients, data incomplete for one case) compared with 11% of benign cases (527 patients) ($P = 0.0068$). Of the cancer cases, 5 gallbladder specimens (38%) had no documented macroscopic abnormality.

Conclusions: Most cancers are suspected from macroscopic appearance but a small number are not, and these may be missed. Emergency cases and older patients are particularly at risk.

0846: PRE-OPERATIVE LIVER ENZYME PREDICTS SURVIVAL AND RECURRENCE AFTER LIVER RESECTION FOR HEPATOCELLULAR CARCINOMA ARISING FROM NON-CIRRHOTIC/NON-FIBROTIC LIVER: A EUROPEAN PERSPECTIVE

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Background: HCC is uncommon in western countries. This study evaluated outcomes and prognostic factors following hepatectomy for HCC arising in non-cirrhotic/non-fibrotic livers.

Methods: Over a 15-year period, patients undergoing hepatectomy for HCC were identified from prospectively maintained database. Patient demographics, pre-operative biochemical and hematological factors, intra- and postoperative clinical details, and tumour pathology were analysed against overall (OS) and disease progression-free (PFS) survival.

Results: 57 patients underwent hepatectomy for non-cirrhotic/non-fibrotic HCC during study period. Median PFS was 22 months and median OS was 37 months, with 3- and 5-year survival rates post-resection of 48% and 39% respectively. 42% developed recurrent disease. In univariate analysis, the liver enzyme ratio was a factor affecting both OS and PFS ($p = 0.002$). There was a significant trend towards poorer OS (Log rank test, $p = 0.04$) for patients with poorly differentiated tumours compared to well and moderately differentiated tumours. Using Cox proportional hazard model analysis, pre-operative liver enzyme ratio was an independent factor for both OS($HR = 3.13$, $p < 0.02$) and PFS($HR = 1.02$, $p = 0.04$) post-hepatectomy. Poorly differentiated tumour